OFFICE USE ONLY	
CHANGE/SET UP DATE	PAYROLL

FORM 6200

Retired Member's Soc. Sec. No.: ☐☐☐-☐☐-☐☐☐☐

Revised November 6, 2002

Retired Member's Name: _____

KENTUCKY RETIREMENT SYSTEMS

HIGH & LOW OPTION COVERAGE (For Medicare Eligible Persons)

APPLICANT'S NAME: _____ SOC. SEC. NO.: _____

HOME ADDRESS: _____
street city state ZIP code

☐ Recipient of the retirement allowance should check this box if this is a new address for the account.

HOME PHONE: _____ DATE OF BIRTH: _____ SEX: _____

☐ I Waive Coverage* Reason for Waiving: _____

* If you waive coverage, you will not be allowed to change this election until the next open enrollment period unless your coverage terminates. If you waive coverage, complete all requested information to this point then skip down to the bottom of the page and provide the necessary signatures.

MEDICARE INFORMATION (copy information exactly from the applicant's Medicare Card)

MEDICARE CLAIM NO: _____

PART A HOSPITAL INSURANCE EFFECTIVE DATE: _____

PART B MEDICAL INSURANCE EFFECTIVE DATE: _____

(IMPORTANT: A COPY OF THE APPLICANT'S MEDICARE CARD MUST BE SUBMITTED WITH THIS APPLICATION)

SELECT ONE INSURER:	**SELECT ONE COVERAGE OPTION:**
Plans Available Nationwide:	
☐ Anthem Blue Seniors' (formerly Anthem BC/BS Seniors)	☐ LOW OPTION (Does **Not** Include Drug Coverage)
☐ Bankers Life and Casualty Company	☐ HIGH OPTION (Includes Drug Coverage)

If you plan to replace any **other health insurance** or if this program will duplicate any other insurance, please note it here:

Provide the name and address of the **CUSTODIAL PARENT**, if the coverage is for a dependent not living with the recipient.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I authorize release of all Medicare Part A and Part B claims information from any source for the purpose of processing my claims. This authorizes release of my Medicare claims information from the effective date of my coverage until termination of my coverage.

APPLICANT'S SIGNATURE: _____ DATE: _____

MEMBER'S SIGNATURE (if different from applicant): _____ DATE: _____

Return to: Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, KY 40601-6124